APPLICATION FOR RECORDS RETENTION SCHEDULE

GEORGIA DEPARTMENT OF HUMAN RESOURCES
OFFICE OF ADMINISTRATIVE SERVICES
RECORDS MANAGEMENT UNIT

For instructions on completing this form contact DHR Records Management Unit, 47 Trinity Avenue, Atlanta, Georgia 30334. Phone - (404) 656-4976 GIST: 221-4983

DHR	1. GEORGIA DEPARTMENT OF HUMAN RESOURCES	ARCHIVES AND HISTORY
Application Date: August 11, 1980 Application Number: DHR 80-25	Division of Physical Health Chronic Disease Unit - Room 102 618 Ponce de Leon Avenue, N.E. Atlanta, Georgia 30308	Application Number: 80-311 Date Received: AUG 1 8 1980 Date Completed: AUG 2 5 1980

2. Person to Contact: Mrs. Kathy Bush **Working Title:** Office Supervisor **Telephone Number:** 894-5122

3. Action Requested

a. ☒ Establish Retention Schedule; record will continue to accumulate.
b. ☐ Dispose of present accumulation; no further accumulation anticipated.
c. ☐ Amend Application No. ______ Check One: ☐ Change; ☐ Supercede; ☐ Void

4. Dates of Series Earliest: 3/1/80 Latest: to present

5. Records Series Title *(followed by title used in office; if different)*

Chronic Disease
Cystic Fibrosis Client Files

6. Division and Office Function What is the function of the Division and the Office in which this record series is created?

The Division of Physical Health, through the leadership of the Director, is responsible for the administration, direction, and coordination of the physical health programs throughout Georgia. This is accomplished by the establishment of health standards for business, housing. and field operations; the improvement of the physical and dental health of adults and children; the diagnosis and control of diseases; the monitoring of supplies of drinking water; and the daily State-wide program of the registration, statistical coding, certification, and preservation of certificates for births, marriages, divorces, annulments of marriage, and deaths that occur each year in the State.

The Chronic Disease Unit has the responsibility to identify, refer, or bring to treatment, adults with major chronic diseases, such as: cancer; stroke and heart attack; kidney; rheumatic fever; high blood pressure; diabetes; speech, vision, and hearing; and cystic fibrosis; to operate and administer programs for: cancer control; aging; rehabilitation services; and FOCUS (Focus on Coordination of Unified Services); and contract with hospitals to provide treatment for persons with kidney diseases who are unable to pay from their own or other resources.

7. Records Series Description This file contains the following documents *(include form numbers and titles, if any)*: Attach samples of the file.

Documents relating to: maintaining medical and financial information on clients in the Adult Cystic Fibrosis Program.

Included are: form ACFP-101 (Patient Evaluation) which shows name of physician and address; patient's name, address, birthdate, age, race, sex, marital status, children under age 18, Social Security number, home phone number, whether or not eligible for Medicaid assistance; whether or not currently enrolled in Medicare Health Insurance; other health insurance coverage; annual adjusted gross income; and certification by patient that information given is true and accurate with signature and date: type of service to be provided by physician (listed) and verification that patient has been diagnosed as having cystic fibrosis and requires services indicated, with signature and date; and signature and date (as to determination of need by patient for financial help) given by Clinic Director or attending physician. ACFP-102 (Request for Payment) shows vendor's name and address; patient's name and address; description of service, equipment, medication, date, invoice number and information as to amount and payment; signature of vendor verifying that the charges shown are true and accurate, and date; signature (Cystic Fibrosis Program personnel approving payment; ACFP-104 (Request for Drug Reimbursement) shows vendor name, address, and county. patient's name, address, and number; itemized list of drugs (listed), prescription number, date filled, quantity, patient's signature, information as to charges and billing; signature of vendor, and date. ACFP-105 (Request for Drug Reimbursement) shows vendor; patient's name, address, county, and number; drugs, date filled, and information as to charges and payment; pharmacy name and address; patient's signature verifying that charges are true and accurate and confirming that patient has made total payment of said charges as shown, and date: and signature of approval (Adult Cystic Fibrosis Program) and date.

The file is arranged:

alphabetically by name of client.

8. Monthly Reference Rate How often are records referred to which are: estimate

One to six months old 5-6 weekly; Seven to twelve months old 8-10; Thirteen to twenty-four months old 2-3 per year; twenty-five months and older

9. Annual Rate of Accumulation of Records estimate

Letter-size drawers 1; Legal-size drawers ______; Shelves ______; Other *(Specify)* ______

YES	NO	10. Questionnaire (Place an "X" in the proper column)
x		a. Is this the official copy of the series? If not, where is it?
x		b. Does the series contain confidential information requiring security handling? If yes, cite law or regulation. records contain client names
	x	c. Is this a vital record?
	x	d. Does this series have historical or long term research value?
	x	e. When one or two documents in the file make it necessary to keep the entire file for a long period, could these documents be scheduled separately?
	x	f. Is the information contained in this series ever published? If yes, attach copy.
	x	g. Is the information contained in this series ever analyzed and/or recorded in a summarized report? If yes, attach copy.
	x	h. Is there a duplication of this series in your office, or in another office or agency? If yes, where?
	x	i. Is this series *(or a major portion of it)* regularly microfilmed?
	x	j. Does the record series result in a computer printout?

11. Retention Requirements The following requires the series to be kept:

a. State Law _____ years.
b. Statute of limitation _____ years.
c. Federal law _____ years.
d. Audit period _____ years.
e. Administrative need 7 years.
f. Federal retention instructions _____ years.

Attach copy or excerpt of laws or regulations. Explain administrative need.

in event information may be needed at some future date for care and/or treatment of patient

12. Approved Disposition Instructions This agency recommends that the file series be cut off at the end of each:

☐ Calendar Year; ☒ Fiscal Year; ☐ Other _____ then,

☒ Hold in the current files area _____ month(s) 2 year(s); then
☐ Transfer to local holding area; hold _____ year(s); then
☒ Transfer to State Records Center; hold 5 year(s); then
☒ Destroy
☐ Transfer to State Archives for permanent retention.
☐ Other *(Specify)*

These instructions apply to all prior and future accumulations of the series.

Agency Head/Designee *(Signature)*	Date	Records Management Officer *(Signature)*	Date
Ruth Moody	8/8/80	Elizabeth W. Crank	7/29/80

Elizabeth W. Crank, CRM
State Records Committee *(Signature)*

Recommendations in paragraph 12 are approved.
(If disapproved, attach letter of explanation.)

		Date
State Auditor/Designee		8-21-80
Secretary of State/Designee		8-19-80
Attorney General/Designee		8-22-80

Form 4903 (7-76) (Reverse Side)